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BEFORE THE
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **BARBARA ANN WILLIAMS** P.O. Box 217 Atascadero, CA 93422 Psychiatric Technician License No. PT 24344 Respondent.	Case No. PT-2010-1653 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Teresa Bello-Jones, J.D., M.S.N., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Vocational Nursing and Psychiatric Technicians, Department of Consumer Affairs.

2. On or about November 20, 1985, the Board of Vocational Nursing and Psychiatric Technicians issued Psychiatric Technician License Number PT 24344 to Barbara Ann Williams (Respondent). The Psychiatric Technician License expired on January 31, 2012, and has not been renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Vocational Nursing and Psychiatric Technicians (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 118, subdivision (b), of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated. Under Code section 4545, the Board may renew an expired license at any time within four years after the expiration.

5. Section 4520 of the Code provides, in pertinent part, that the Board may discipline any licensed psychiatric technician for any reason provided in Article 3 (commencing with section 4520) of the Psychiatric Technicians Law (Code § 4500, et. seq.)

6. Section 4521 of the Code states:

"The board may suspend or revoke a license issued under this chapter [the Psychiatric Technicians Law (Bus. & Prof Code, 4500, et seq.)] for any of the following reasons:

"(a) Unprofessional conduct, which includes but is not limited to any of the following:

(1) Incompetence or gross negligence in carrying out usual psychiatric technician functions.

. . .

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision or terms of this chapter.

. . .

"(n) The commission of any act involving dishonesty, when that action is substantially related to the duties and functions of the licensee.

. . .

REGULATORY PROVISIONS

7. California Code of Regulations Title 16, section 2576.5 provides:

The licensed psychiatric technician performs services requiring technical and manual skills which include the following:

(a) Uses and practices basic assessment (data collection), participates in planning, executes interventions in accordance with the care plan or treatment plan, and contributes to evaluation of individualized interventions related to the care plan or treatment plan.

(b) Provides direct patient/client care by which the licensee:

(1) Performs basic nursing services as defined in subdivision (a);

(2) Administers medications;

(3) Applies communication skills for the purpose of patient/client care and education; and

(4) Contributes to the development and implementation of a teaching plan related to self-care for the patient/client.

8. California Code of Regulations Title 16, section 2576.6 provides:

(a) A licensed psychiatric technician shall safeguard patients'/clients' health and safety by actions that include but are not limited to the following:

(1) Reporting to the Board acts specified in Section 4521 of the Business and Professions Code;

(2) Documenting patient/client care in accordance with standards of the profession; and

(3) Performing services in accordance with Section 125.6 of the Business and Professions Code.

. . .

(c) A violation of this section constitutes unprofessional conduct for purposes of initiating disciplinary action.

9. California Code of Regulations, title 16, section 2577, states:

"As set forth in Section 4521 of the code, gross negligence is deemed unprofessional conduct and is grounds for disciplinary action. As used in Section 4521 'gross negligence' means a substantial departure from the standard of care which, under similar circumstances, would have

ordinarily been exercised by a competent licensed psychiatric technician, and which has or could have resulted in harm to the consumer. An exercise of so slight a degree of care as to justify the belief that there was a conscious disregard or indifference for the health, safety, or welfare of the consumer shall be considered a substantial departure from the above standard care."

10. California Code of Regulations, title 16, section 2577.1, states:

"As set forth in Section 4521 of the code, incompetence is deemed unprofessional conduct and is grounds for disciplinary action. As used in Section 4521, 'incompetence' means the lack of possession of and the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by responsible licensed psychiatric technicians."

COST RECOVERY

11. Section 125.3 of the Code provides, in pertinent part, that a Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

SUMMARY OF FACTS

12. The following facts are common to all causes for discipline alleged in the Accusation:

A. The subject events occurred on or about March 29 and March 30, 2008, during the "night shift" (from 11:00 pm (2300 hours) to 7:00 am (0700 hours)) at Atascadero State Hospital, a secure facility for treatment of mentally ill criminal offenders operated by the California Department of Mental Health ("Atascadero").

B. At all times relevant herein, Respondent Barbara Williams was employed as a psychiatric technician at Atascadero, having been hired in 1985. On or about March 29 and March 30, 2008, she was on duty on as a Psychiatric Technician, assigned to the night shift on **Unit 22** (a unit of approximately 34 beds). On that night, Respondent Williams arrived on the Unit at approximately 2300 hours, and immediately began work in the medication room, where she was tasked with counting medications and auditing supplies.

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C. At all times relevant herein, Geoffrey Gough was employed as a Senior Psychiatric Technician at Atascadero, and was on duty as the Supervisor or "Shift Lead" of Unit 22 during the subject shift.

D. The duties, responsibilities and required skills of Respondent William's position at Atascadero, according to the **Psychiatric Technician's Duty Statement**, signed by Respondent on or about March 4, 2008 included:

> "Major Tasks, Duties, And Responsibilities", "Psychiatric Technicians work to maintain order and supervise the conduct of clients/patients; to protect and maintain the safety of persons and property; to provide a basic level of general behavioral psychiatric nursing care to clients/patients who are mentally disordered; and to participate in the overall psychiatric treatment program."
>
> . . .
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> "Knowledge And Abilities", "Knowledge of: . . .fundamentals of nursing care, general behavioral and psychiatric procedures involved in the care and treatment of individuals or groups of mentally disordered clients/patients:. . . hospital procedures" and "Ability to:. . . . learn and apply sound judgment for situations including the protection of persons and property; apply basic nursing knowledge, skills, and attitudes; . . .recognize symptoms requiring medical or psychiatric attention; think and act quickly in emergencies; . .. analyze situations accurately and take effective action".

E. At all times relevant herein, Atascadero State Hospital policies and procedures, in which Respondent received training, included **Administrative Directive No. 810**, provided at Paragraph III (C) with regard to observation rounds:

> " Observation Rounds:
>
> 1. Staff will provide for patient safety by directly observing patients and patient-occupied areas. Unit staff shall make observation rounds of all patient-occupied areas at least three (3) times each hour at irregular intervals. Intervals between rounds shall not

exceed 20 minutes. This does not preclude staff from making rounds more frequently based upon safety or security needs on the unit.

2. If patients are sleeping at the time rounds are concluded, the employee must see movement or otherwise ensure that there is a living, breathing patient in the bed area.

3. Two staff members shall remain out of shift change and assigned to make continuous rounds and be available to patients.

4. The Unit Supervisor, through the shift leads, will ensure that observation rounds are documented in the unit logbook."

F. Night shift staff were required by hospital policies to make and document both **observation rounds** (every 20 minutes per Directive 810) and census counts (at 2300 hours, 0300 hours and 0600 hours per Atascadero Directive 804). Documentation consists of the staff person writing his initials next to pre-printed times on a form in the **Unit 22 Day Book -** also referred to as the Unit's **Daily Log Book -** when the round or count is completed.

G. Day Book entries made during the subject shift appear to show that staff conducted observation rounds every 20 minutes, and that Unit Staff conducted all required census counts – but discovered no irregularities.

Attack on Patient C

H. At all relevant times herein, **Patients M, C** and **LR** were residents of Unit 22.

I. For weeks prior to the subject dates, Patient M had become increasingly aggressive with angry verbal threats and assaultive behavior toward other Unit 22 patients, particularly targeting homosexual patients.

J. Shift Supervisor Geoffrey Gough later reported that at or about 0310 hours (3:10 am) he heard a "loud desperate yelling" on the Unit – and was directed by patients "standing out in the hall" to the room of Patient C. Flipping on the light switch (which is outside of the room) and entering the room, Gough observed Patient C on his knees but leaning forward onto his bed, with his upper body "sprawled" across the bed, and screaming loudly. Patient M was beating Patient C, with what Gough later described as "continuous pounding" of his fists on Patient C's head,

back and shoulders. Patient M continued pounding Patient C as Gough entered the room – but M stopped the attack and did not resist once Gough grabbed him by the shoulders. Gough then took M out of the room.

K. Respondent Williams later reported that at approximately 0305-0310 hours (3:05-3:10 am) she was in the medication room when she heard screaming – then saw Gough running down the hallway as he attempted to identify where the screams were coming from. She joined him, and entered Patient C's room with the attack in progress.

Restraint of Patient M

L. Gough took Patient M to the "Dayroom" on Unit 22, where he was monitored on one-to-one supervision, then placed in locked room seclusion.

Discovery of Deceased Patient

M. Later that morning - on March 30, 2008, at 0750 hours (7:50 am), **Patient LR** was found dead in his single bed room on Unit 22 at Atascadero.

N. In its autopsy report, the San Luis Obispo County coroner determined that Patient LR had died from "ligature strangulation" and that the death was a homicide. He was found face down on his bed with a white towel – used as a ligature – twisted tightly around his neck. His face and neck were deeply discolored with lividity. Blood was on Patient LR's face and bedspread, and his room was in a disordered state – suggesting a struggle had occurred. The patient also had multiple facial abrasions and the imprint of a shoe on his upper mid-back.

O. Atascadero investigators quickly focused suspicion on Patient M – given the attack on Patient C and his history of threats and assaultive behavior. Patient M was later charged and on or about August 27, 2009, convicted on his plea of guilty of second degree murder for Patient LR's death.

Time of Death

P. The Coroner estimated time of death to have been between 0100 hours (1:00 am), when Patient LR was last seen alive - and 0750 hours (7:50 am), when his body was found. However, it appears likely that his death occurred in the approximately 2 hour period between 0100 hours (when he was last seen alive) and 0310 hours – after which M was under continuous

observation.

Q. Because Patient LR was determined to have been strangled to death between 0100 and 0310 hours (1:00 – 3:10 am), but was *not discovered* to be deceased until approximately 0750, it is not possible for Unit staff to have properly performed observation rounds and/or census counts between approximately 0310 and 0750.

Admissions of Misconduct by Geoffrey Gough

R. During testimony in the criminal matter against Patient M, and in statements to Atascadero State Hospital Police Department officers and the Board subsequent to the subject events, Gough admitted that on the subject date, he had not complied with Directives 804 and 810 in the manner in which he conducted observation rounds and census counts, and that he had falsified entries in hospital records showing when and by whom the observation rounds and census counts were conducted.

Admission of Misconduct by Respondent Williams

S. In an interview conducted by Atascadero investigators in June, 2008, Respondent Williams admitted that she had conducted approximately *five (5) observation rounds at times between 2340 and 0300 hours (11:40 pm and 3:00 am),* but that she had made no entries in the Unit 22 Day Book – as Gough had made any/all entries for the observation rounds she had conducted.

T. During the observation rounds conducted at that time - she observed and reported no irregularities.

U. Respondent told investigators that she is 5'2" - and stated that it was her customary practice to conduct observation rounds by positioning herself at each room window – then stand on her toes, while using her fingertips to pull herself up enough to look in the window - in order to check patient rooms without entering.

V. Respondent admitted that during the subject shift, she conducted observations rounds in her customary manner. She did not check for signs of life. She stated that she did not open the door to enter any of the patients' rooms. She did not use a flashlight – indicating she wanted to keep her hands free to pull herself up at patient room windows.

W. In August of 2008, Atascadero investigators conducted a crime-scene re-construction with Respondent's participation, to determine how much of a patient's room was visible to Respondent, when using her customary observation technique. During the re-construction, Respondent admitted that, using her customary observation technique – she was unable to see the entire bed, unable to see the floor of the room, and otherwise unable to see into the patient's room as previously claimed.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

13. Respondent WILLIAMS is subject to disciplinary action under section 4521(a) (1) on grounds of unprofessional conduct as defined in California Code of Regulations, Title 16, section 2577, in that while on duty as a psychiatric technician assigned to the Unit 22 night shift on or about March 29 and March 30, 2008, at Atascadero, Respondent committed acts of gross negligence, each of which was a substantial departure from the standard of care:

A. Respondent was grossly negligent due to her failure to conduct and complete observation rounds on Unit 22 in compliance with hospital procedures, policies and administrative directives including but not limited to **Directive 810.**

B. Respondent was grossly negligent due to her failure to correctly document observation rounds on the unit in compliance with hospital procedures, policies and administrative directives.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

14. Respondent WILLIAMS is subject to disciplinary action under section 4521(a) (1) on grounds of unprofessional conduct as defined in California Code of Regulations, Title 16, section 2577.1, in that while on duty as a psychiatric technician, assigned to the Unit 22 night shift on or about March 29 and March 30, 2008, at Atascadero, Respondent committed acts of incompetence as follows:

A. Respondent was incompetent in her failure to conduct observation rounds on Unit 22 in compliance with **Directive 810.**

B. Respondent was incompetent due to her failure to correctly document observation rounds, census counts and activities on the unit in compliance with hospital procedures, policies and administrative directives.

THIRD CAUSE FOR DISCIPLINE

(Commission of Act Involving Dishonesty)

15. Respondent WILLIAMS is subject to disciplinary action under section 4521(n) on grounds of unprofessional conduct, in that Respondent, while on duty as a psychiatric technician during his normal working shift on or about March 29 and March 30, 2008, at Atascadero, Respondent committed acts of dishonesty which were substantially related to the duties and functions of the license, by reason of the following facts:

A. Respondent lied to Atascadero investigators about her ability to see clearly and completely into a patient's room while conducting observation rounds. Respondent maintained this falsehood until she was unable to identify objects and areas in the room during an investigative crime-scene reconstruction.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Document Patient Care In Accord With Professional Standards)

16. Respondent WILLIAMS is subject to disciplinary action under section 4521(a) of the Code, in conjunction with the California Code of Regulations, title 16, section 2576.6(a)(2), for unprofessional conduct in that while on duty as a psychiatric technician on or about March 29 and March 30, 2008, at Atascadero, in that Respondent failed to document patient care in accord with professional standards as follows:

A. By her own admission, Respondent conducted five observation rounds, but made no entries in the Day Book - instead, she allowed her supervisor (Gough) to made all/any entries in contravention of hospital policies.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Safeguard Patient's Health and Failure to Perform Basic Patient Care Services)

17. Respondent WILLIAMS is subject to disciplinary action under section 4521(a) of the Code, in conjunction with the California Code of Regulations, title 16, section 2576.5(b)(1)

and/or title 16, section 2576.6(a) for unprofessional conduct in that while on duty as a psychiatric technician assigned as supervisor of the Unit 22 night shift on or about March 29 and March 30, 2008, at Atascadero State Hospital, in that Respondent failed to perform basic patient care services, and/or failed to safeguard patient's health and safety by failing to ensure that the Unit 22 residence rooms and hallways were properly monitored and/or supervised. Respondent thus allowed Patient M to leave his own room, move freely about the hallway, and enter the rooms of Patients C and LR.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Vocational Nursing and Psychiatric Technicians issue a decision:

1. Revoking or suspending Psychiatric Technician License Number PT 24344, issued to Barbara Ann Williams;

2. Ordering Barbara Ann Williams to pay the Board of Vocational Nursing and Psychiatric Technicians the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: May 24, 2013

TERESA BELLO-JONES, J.D., M.S.N., R.N.
Executive Officer
Board of Vocational Nursing and Psychiatric Technicians
Department of Consumer Affairs
State of California
Complainant

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